

National Health Service Corps

information bulletin

PRIVATE PRACTICE OPTION

April 1986

U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Care Delivery and Assistance

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INTRODUCTION

The Private Practice Option (PPO) is a National Health Service Corps (NHSC) placement alternative in which NHSC scholarship recipients may fulfill all or part of their service obligation by the full-time private clinical practice of their profession in locations designated on the Health Manpower Shortage Area Placement Opportunity List (HPOL). A practitioner under the PPO may provide health services as:

1. a solo practitioner,
2. a member of a group practice, or
3. as a salaried employee or member of any private or public entity directly providing health services.

This Bulletin describes NHSC policies for the PPO, effective for all individuals in or entering the program on or after April 2, 1985.

ELIGIBILITY

A NHSC scholarship recipient who has completed, or is scheduled to complete within 1 year, the academic training for which the scholarship was awarded and the postgraduate training, if any, for which deferment was granted is eligible to apply for the PPO. Application may be made any time within 1 year before starting the service obligation through the entire service obligation.

APPLICATION

Health professionals are encouraged to apply for the PPO under the Early Decision Alternative (EDA) feature to obtain the widest choice of practice locations. The EDA permits professionals to apply for a practice site in any location specified in the HPOL. The EDA is available between 9 and 12 months before the service obligation begins and before the professional is allocated to a State or region by the NHSC. Due to the changing nature of Health Manpower Shortage Area (HMSA) designations, once selected, the site is subject to final NHSC validation before an agreement is entered. If the site does not meet validation requirements, the PPO applicant, whenever possible, will be assigned to another site in the same State.

The current HPOL and HMSA listings and the validation dates are obtained from regional offices.

Health professionals currently serving as members of the NHSC are eligible to apply for the PPO at any time, but the private practice must be located in the HMSA in which they are currently serving and must be in an appropriate clinical setting and rational service area.

Applications for the PPO in emergency room settings from the HPOL vacancies will be approved only for health professionals who:

1. were deferred by the NHSC for emergency room training,
2. have completed their residency training in emergency medicine; and
3. are board eligible or board certified in emergency medicine.

Applications for the PPO for an obstetrics/gynecology practice will be approved only when the practice is on the HPOL and will offer the full range of obstetrical services, including prenatal, intrapartum, and postpartum. The practice must meet other conditions which include, but are not limited to:

1. the site where the practice is located must have at least one hospital facility that has been approved by the Joint Commission on Accreditation of Hospitals at Level I and is within a reasonable distance from the site. A referral mechanism for Level II or Level III hospitals must be in place.
2. At least one other obstetrician/gynecologist (or family/general practitioner trained in obstetrics) must be available within the site locale for back-up coverage.
3. The practice must be integrated with the activities of the local and State Maternal and Child Health programs.

PARTICIPATION REQUIREMENTS

Written Agreement

An applicant whose request for the PPO is approved is required to enter into a written agreement with the Secretary describing the terms and conditions of the practice. These may vary with the type of practice to be conducted, location of the practice and other circumstances, but each PPO agreement must contain at least the provisions listed below.

Period of PPO Service

Applicants must agree to engage in the full-time private clinical practice of their health profession for a period equal to their service obligation or for the time remaining thereto.

Practice Location

The practice must be located in an appropriate clinical setting within the geographic boundaries of the HMSA specified on the HPOL and at the office address specified in the written agreement.

A health professional is expected to serve the obligation in the HMSA to which initially assigned and may not move the practice outside the HMSA being served. In the event of practice failure, the practitioner will be reassigned by the NHSC to a site selected on the basis of the needs and priorities of the Public Health Service.

Service in a HMSA Through the HPOL

State agencies and the regional offices review all HMSAs in order to select those with the greatest need for placement of NHSC health professionals. The NHSC then determines which HMSAs have the greatest need and can support a full-time clinical private practice. These HMSAs are then placed on the HPOL as PPOs. A separate HPOL is prepared for each health profession and specialty.

At least 80 percent of the patients served must be residents of the HMSA in which the practice is located. If this percentage is not met, the practice will be held to be in violation of this provision. The health professional will be given the opportunity to rebut the presumption of violation by providing evidence to sustain the position.

Licenses and Permits

The practitioner must have a professional license from the State in which the practice is to be located before the practice begins. Credit towards the fulfillment of the scholarship service obligation will not be given in the absence of a valid license.

In addition, the health professional is expected to meet all other State requirements, as well as local and Federal requirements that may be necessary and must obtain all necessary licenses, permits, and other documents.

The practitioner must obtain the permission of the Drug Enforcement Agency to prescribe and maintain controlled substances and must obtain an identification number if the prescription and maintenance of controlled substances is appropriate for the practice.

Full-Time Private Clinical Practice

Applicants must agree to engage in the full-time private clinical practice of the profession for which the NHSC scholarship was awarded.

For physicians, a full-time practice will consist of a minimum of 40 hours per week for 45 weeks per year and will include hospital treatment coverage appropriate to meet the needs of patients and to assure continuity of care. For all physicians except obstetricians/gynecologists (OB/GYNs), at least 32 of the minimum of 40 hours per week must be expended at the office specified in the written agreement, providing health services to patients during normally scheduled office hours. For an OB/GYN practitioner, the majority of the 40 hours per week (no less than 21 hours per week) is expected to be expended at the office during normally scheduled office hours.

The 40 hours per week may be compressed into no less than 4 days per week with no more than 12 hours of work to be performed in any 24-hour period. Time spent in an "on-call" status will not count toward the 40-hour week. This is applicable to all physicians including emergency room.

Malpractice Insurance

Health professionals in the PPO must obtain their own malpractice insurance in accordance with appropriate State requirements. Professionals providing services under the PPO are not protected by the Government under the Federal Tort Claims Act against personal liability for alleged malpractice.

Charges for Services

The applicant must agree to charge patients at the usual and customary rate prevailing in the HMSA in which services are provided. However, services must be at a reduced charge or no charge for persons unable to pay for them. In addition, persons must be charged where third parties are authorized and under legal obligation to pay the charges.

Inability to Pay

The applicant must agree that no person receiving health services will be discriminated against because of:

1. an inability to pay for the health services, or because
2. payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

A presumption will be raised that the practice is in violation of this provision under the following conditions:

1. If the percentage of patients served by the practice who are provided health services at a reduced charge or no charge because of an inability to pay for services is less than the State percentage of patients unable to pay for services in the State in which the practice is located; or
2. If the percentage of patients served by the practice who pay for services through Medicare is less than 80 percent of the State percentage of patients who pay for services through Medicare in the State in which the practice is located; or
3. If the percentage of patients served by the practice who pay for services through Medicaid is less than the State percentage of patients who pay for services through Medicaid in the State in which the practice is located. In these instances, the individual will be given an opportunity to rebut this presumption by providing evidence sufficient to demonstrate that no violation has occurred.

Accept Medicare Assignments

The applicant must agree to accept assignments under Section 1842(b)(3)(B)(ii) of the Social Security Act as full payment for all services for which payment may be made under Part B of Title XVIII of the Act. Appendix A is a description of the Medicare program and Medicare billing for NHSC physicians.

Medicaid Agreement

The PPO applicant must agree to enter into an agreement with the State agency administering the State plan for medical assistance under Title XIX of the Social Security Act.

Public Notice of Charges for Services

A notice must be posted in a conspicuous location in the patient waiting area notifying patients of the Charges for Services as set forth in the preceding paragraphs and the written agreement. The regional office will furnish a copy of the notice to each private practice. Appendix B is an example of a public notice of charges for services.

Reports

The PPO applicant must agree to prepare and submit a semiannual report relating to the conduct of the practice and reflecting the requirement of the PPO agreement to receive credit towards the fulfillment of the scholarship service obligation. To avoid default, the reports must be submitted in a timely manner.

The NHSC may, from time to time, require the submission of reports and documents in addition to the semiannual reports.

Monitoring

Provisions of the PPO agreement give the NHSC authority to monitor health professionals to determine whether the requirements for conducting their private practice are being met. Monitoring may be in the form of periodic visits by NHSC representatives, requests for written reports and documentation, telephone conversations, inspection of records and patient schedules, and interviews.

Information that the health professional may be required to furnish may include, but is not limited to, patient and hospital visitation schedules; office hours; financial and other records documenting that health services are being provided for patients unable to pay; financial and other records documenting that the requirements for participation in the Medicare and Medicaid program are being fulfilled; and other documents relating to the conduct of the private practice, such as leases or service contracts.

The NHSC may from time-to-time conduct assessments of program effectiveness and quality. The health professional shall cooperate with the NHSC during the assessments

Practice Records

Practice records must be maintained in form and content enabling the NHSC to determine if the health professional is complying with the terms and conditions of the PPO and written agreement. Practice records are required to be maintained for 3 years after the expiration date of the written agreement. The records shall be retained beyond the 3-year period if an audit is in progress or if any audit findings have not been resolved.

Access to all Records

The professional is required to cooperate with the NHSC during onsite examination of records and to grant NHSC representative access to all records maintained by the practice pertinent to ascertaining compliance with the requirements of PPO policies and the written agreement. In such reviews the NHSC will be responsible for maintaining the confidentiality of records.

Medical Care Standards of Practice

The PPO applicant must agree to conduct the medical practice within generally accepted standards of good medical care. Standards for good medical care include those established by a specific medical community (e.g., a hospital staff, a group practice, or the physicians in a defined geographical area), those established by a government licensing board or agency, and those established by a specific professional discipline. Medical care practice standards relate to direct patient care practices, scope of practice, after hours coverage, office management, record keeping, billing policies, advertising, and other aspects of practice operation.

The applicant is not expected to practice beyond the scope of his specialty or training limitations in providing medical care; however, a good standard of medical care includes the assurance of referral sources for those patients requiring additional care beyond the provider's expertise. After hours coverage standards include assuring that patients have reasonable access to acceptable medical care during non-scheduled office hours, weekends, and holidays.

VERIFICATION OF PPO REQUIREMENTS

Health professionals should work closely with the NHSC State and regional representatives in the developmental stages of a private practice to assure that requirements for a PPO agreement are being met. The responsibility for deciding whether the requirements are met rests with the NHSC.

DOCUMENTATION TO BE PROVIDED

The health professional must provide copies of the documents listed below to the appropriate regional office before beginning the practice. An application for the PPO is considered to be incomplete until the documentation is filed with the regional office, nor will the written agreement be signed by the Secretary until the documentation is in. The documents to be filed will depend on the applicant's profession and specialty.

1. Licensure: A copy of the professional license issued by the State in which the practice is to be located.
2. Medicare and Medicaid: Letters from the Medicare and the Medicaid programs in the State in which the practice is to be located stating that the health professional has been accepted as a health care provider in the programs and providing the identification number of the health professional.
3. Drug Enforcement Agency: A statement from the Drug Enforcement Agency providing an identification number and indicating the health professional has been granted the right to prescribe and maintain controlled substances.
4. Hospital Privileges: Letter(s) from hospital(s) which indicate that the health professional has been granted hospital privileges.

5. Other: A copy of any other local, State, or Federal licenses, permits, or other documentation applicable to the health professional and the practice.

MODIFICATIONS TO THE PRIVATE PRACTICE AND WRITTEN AGREEMENT

Any modification to the private practice and written agreement that the practitioner may contemplate must be communicated to and approved by the regional office before it is adopted. The health professional will automatically be placed into default status if changes of any nature are made in the private practice and the written agreement without the prior written approval of the NHSC, the subsequent execution of a new written agreement between the health professional and the Secretary, and the filing of the revised written agreement in the regional office.

EFFECTIVE DATE OF THE WRITTEN AGREEMENT

The written agreement and the starting date of the practice will be binding when the following conditions have been met and the Regional Health Administrators have approved the agreement:

1. The NHSC has completed the final validation in determining that the HMSA in which the practice is to be located remains eligible for designation and inclusion on the HPOL and has so notified the PPO applicant in writing.
2. All the required documentation is filed with the regional office, including evidence of licensure, hospital privileges, Medicare and Medicare participation, Drug Enforcement Agency permission to prescribe and maintain controlled substances, and other licenses and permits that may be required.
3. A written agreement has been executed between the applicant and NHSC and submitted to the regional office.

The applicant is cautioned against making personal commitments (such as the purchase or rental of an office and the hiring of staff) until the official notification from the NHSC has been received that the NHSC has completed the final validation process and has determined that the HMSA in which the practice is to be located remains eligible for HMSA designation and inclusion on the HPOL.

DEFAULT PENALTY FOR FAILURE TO FULFILL OBLIGATION

NHSC Scholarship Program Only

A health professional who has received a scholarship solely under Section 338A of the Public Health Service Act (the NHSC Scholarship program), and who fails to begin or complete the private practice obligation in accordance with the terms of the agreement entered into, becomes liable for paying to the United States a default penalty equal to an amount determined under the formula set forth in Section 338D(b)(1) of the Act, as amended. This formula provides for payment of three times the amount of the NHSC scholarship award received, plus interest, at the maximum legal prevailing rate.

If, however, the health professional performs a period of full-time private clinical practice before a default occurs, that period of service may be credited to the total private practice obligation incurred, thus reducing the amount of money owed. The defaulted amount must be paid within 1 year of the date, as determined by the NHSC, of the health professional's failure to begin or complete the private practice obligation. A longer period for payment may be specified by the Government for good cause shown.

PH/NHSC Scholarship Training Program Only

Any health professional who received a scholarship solely under the Public Health and National Health Service Corps (PH/NHSC) Scholarship Training program (Section 225 of the Act) and fails to begin or complete the private practice obligation in accordance with the terms of the agreement will be subject to the default penalty specified in Section 225(f) of the Act. This section provides for payment of the total amount of the PHS scholarship award received, plus interest, at the maximum prevailing rate as prescribed in the District of Columbia Code. The payment must be made within 3 years of the date on which the health professional failed to begin or complete his private practice obligation.

Both Scholarship Programs

Any health professional who (1) has received a scholarship under both the PH/NHSC Scholarship Training program (Section 225 of the Act) and the NHSC Scholarship program (Section 338A of the Act), and (2) fails to begin or complete the private practice obligation in accordance with the terms of a PPO agreement entered into, will be subject to the default

penalty specified in Section 225(f) of the Act for that portion of the total private practice obligation incurred under the PH/NHSC Scholarship Training program, and will be subject to the default penalty under Section 338D(b)(1) of the Act for that portion of the total private practice obligation incurred under the NHSC Scholarship program. This split default penalty will be applied to the total private practice obligation in the order in which the service obligations were incurred, and the service obligations will be considered to have been served in the order in which they were incurred.

PRIVATE PRACTICE LOANS

Health professionals entering the PPO are eligible to apply for a limited number of loans to assist in establishing their practices. Loans are available from the start of the scholarship service obligation up to 1 year following completion of the obligation.

Loan Amounts

During fiscal year 1984, loans were limited to \$12,500 to each awardee. The loan amounts for fiscal year 1986 (October 1985 - September 1986) and beyond will be announced when funding levels become known.

Service Period

Health professionals receiving loans are to practice in accordance with the loan agreement for a period of 1 or 2 years, depending upon the amount of the loan. The period of service may be fulfilled concurrently with any remaining PPO service obligation.

Interest and Payments

Loans have to be repaid within 5 years; interest only to be paid the first 2 years, and the principal plus interest the following 3 years. The borrower has the right at any time to prepay all or part of the unpaid balance of the loan without penalty.

Current interest rates, requirements, and further explanation of the loan programs are provided in separate information bulletins available from the regional offices.

DEFERMENT OF STUDENT LOAN REPAYMENTS

Health professionals are eligible to apply for the deferment of payments of Health Education Assistance Loans during their service obligation under the PPO. Information on deferment of payments may be obtained from the lending institution and the loan program.

Deferment of payments is not available for participants in the Federal Health Professions Student Loan, Nursing Student Loan, or Guaranteed Student Loan programs.

TECHNICAL ASSISTANCE

Subject to the availability of funds, technical assistance may be provided for developing management aspects of PPO practices. In addition, orientation and in-service conferences may be conducted periodically. Health professionals should contact their NHSC regional representative to inquire about this assistance.

TRAVEL AND TRANSPORTATION ALLOWANCES

The NHSC may pay a health professional who has entered into a PPO agreement an amount to cover all or part of the health professional's reasonable expenses incurred in relocating to the site of the practice, including travel expenses for self and family and transportation of personal, business, and household effects. The amount of payment is subject to the Department of Health and Human Services' rules and regulations and the availability of appropriated funds. No arrangements for a move can be made before final approval is received from the regional office.

MEDICARE FACT SHEET FOR NHSC PHYSICIANS

Introduction

This fact sheet is designed to provide a brief description of the Medicare program and Medicare billing for NHSC physicians who bill or plan to bill Medicare on an individual fee-for-service basis. Much more comprehensive information can be obtained by contacting the provider relations office of the local Medicare carrier which will provide physicians handbooks, office orientation and continuing information on the program. If you do not know the name and telephone number of the local Medicare carrier, contact the local or State medical society or call Health Care Financing Administration Public Inquiries Offices at 301 594-8716.

Definitions

1. **Medicare:** Title XVIII of the Social Security Act. Medicare is a Federal health benefits program for the aged and disabled which is administered the Health Care Financing Administration (HCFA). Medicare Part A, is the Hospital Insurance Benefits program which covers institutional care. Medicare Part B, is the Medical Insurance Benefits Program which covers inpatient and outpatient physician services and other outpatient services. The beneficiary pays a monthly premium for Medicare Part B, and is responsible for an annual deductible (\$75.00 as of January 1, 1983) and 20 percent copayment.
2. **Medicaid:** Title XIX of the Social Security Act. Medicaid is a State administered health benefits program for low-income people. Older individuals who have low incomes may have both Medicare and Medicaid coverage. In such cases, Medicare provides first coverage and Medicaid provides supplemental coverage (see Coordination of Benefits).
3. **Deductible:** A specific dollar amount which the beneficiary must pay before the insurance begins to pay (\$75 dollars for Medicare Part B). After called "first dollar" since the beneficiary is responsible for paying the first \$X before the insurance company becomes responsible for paying.

4. Copayment: A fixed amount or percentage which the beneficiary must pay for each covered service after the deductible has been met (20 percent for Medicare Part B).
5. Carrier: An organization, usually an insurance company, which processes Medicare Part B claims under contract with HCFA. In general, the carrier is responsible for provider relations, claims processing, claims review, and claims payment.
6. Acceptance of Assignment: The provider agrees to accept the maximum allowable fee set by Medicare and not bill the beneficiary for the difference between the submitted fee and the maximum allowable fee for covered services. The provider can still bill the beneficiary for any deductible and copayment (based on the maximum allowable fee) due from the beneficiary and the full amount of noncovered services. Under the Medicare program, providers can choose to accept assignment or not accept assignment on each claim submitted. However, NHSC providers and the Bureau of Health Care and Assistance funded organizations must accept assignment.
7. Covered services (benefits): Those services which are paid for by the insurance company. In general, Medicare Part B, covers physician services for inpatient care and for outpatient care associated with an active diagnosis. Most outpatient ancillary tests associated with an active diagnosis are also covered. Medicare Part B, does not cover routine physicals, eye refractions, outpatient pharmacy and certain procedures which have been determined to be of little diagnostic or therapeutic value.
8. Submitted fee: The provider's actual fee for the service or procedure.
9. Customary fee: The usual fee submitted by the provider for the service or procedure, as reflected in the provider's claims profile maintained by the Medicare carrier. A minimum of three claims for the procedure must be submitted within the past twelve months by the provider to establish a customary fee.
10. Prevailing fee: The usual fee submitted by providers in the same specialty for the service/procedure, as reflected in the areawide provider claims profile for that specialty maintained by the Medicare carrier. The prevailing fee is set at the 50th percentile of the areawide profile for providers who have participated in the local Medicare program for than a year. It is set at the 75th percentile for providers who have participated more than 1 year. Carriers update the profiles annually using the most recent 18 months of claims data.

11. Coordination of Benefits: The order of precedence when the beneficiary has two or more insurance coverages. Currently, Medicare is always first payor, subsequent payors pay for deductibles, copayments and services which they cover but which Medicare does not cover (e.g., routine physicals, outpatient pharmacy). Therefore, when a patient has both Medicare and Medicaid coverage, the claim must first be submitted to the Medicare carrier. After Medicare pays, the claim and explanation of benefits (see below) must be submitted to Medicaid.

How to Become an Approved Medicare Provider

1. Contact the local Medicare carrier provider relations office and request an application. The application will include:
 - provider name;
 - practice address(es);
 - former practice address;
 - licensure number;
 - Social Security or EEIN number; and
 - specialty
2. The carrier will review the application and assign a provider number.
3. The local provider relations office will send the provider a supply of claims forms, an instruction book and, usually, provide an in-office orientation for the provider and office staff.
4. On an ongoing basis, the provider relations office will send information bulletins and provide "in-service" training for office staff.

How to Submit Claims

1. The provider completes the Medicare claim for (HCFA-1500, see Attachment A) and submits the claim to the carrier.

2. The carrier verifies beneficiary eligibility and reviews the claim to determine the maximum allowable Medicare fee.
 - a. For a provider who has participated in the local Medicare program for less than a year, the maximum Medicare fee is the lesser of the submitted fee, the provider's customary fee or the prevailing fee (50th percentile of the areawide profile for the specialty).
 - b. For a provider who has participated in the local Medicare program for more than a year, the maximum allowable Medicare fee is the lesser of the submitted fee, the provider's customary fee or the prevailing fee (75th percentile of the areawide profile for the specialty).
3. The carrier sends the provider a check for the Medicare portion of the fee with an explanation of benefits which shows the amount submitted, the amount allowed, the amount paid by Medicare and deductibles and copayments due from the patient.

Claims Accounting

1. Since all NHSC providers must accept assignment for covered services, they must accept the maximum allowable fee set by Medicare as the full fee for the claim. They cannot bill the patient the difference between the submitted fee and the maximum allowable fee.
2. The provider can bill the patient for all deductibles and copayments due from the patient and the full amount for noncovered services. Billing for deductibles and copayments should be done after the provider has received payment and the explanation of benefits from the Medicare carrier.
3. Example A:

Submitted fee: \$125

Medicare maximum allowable fee: \$100

Patient has not met any of his/her \$75 deductible for the year.

Billed to Medicare	\$125 (providing actual fee)
Allowed by Medicare	<u>-100</u> (reasonable charge as established by Medicare)
Written off as reduction.	\$ 25 (cannot be billed to anyone)

Allowed by Medicare	\$100	
Patient deductible	- 75	(due from patient) (annual deductible)
	<u>\$ 25</u>	
80% paid by Medicare	- 20	(coinsurance)
Patient copayment	<u>\$ 5</u>	(due from patient)

Recap

Write-off as a contract reduction	\$ 25
Paid by Medicare	20
Due from patient	<u>80</u>
TOTAL	\$125

4. Example B

Same as A, except patient has met \$50 of his/her \$75 annual deductible.

Billed to Medicare	\$125	
Allowed by Medicare	-100	
Written off as reduction	<u>\$125</u>	
Allowed by Medicare	\$100	
Patient deductible	- 25	(due from patient)
	<u>\$ 75</u>	
80% paid by Medicare	- 60	
Patient copayment	<u>\$ 15</u>	(due from patient)

Recap

Write-off as a reduction	\$ 25
Paid by Medicare	60
Due from patient	<u>40</u>
TOTAL	\$125

5. Example C

Same as B, except patient is in the 25 percent payment sliding fee scale category (i.e., gets a 75 percent discount).

Billed to Medicare	\$125
Allowed by Medicare	-100
Written off as reduction	<u>\$ 25</u>

Allowed by Medicare	\$100	
Patient deductible	- 25	(due from patient)
	<u>\$ 75</u>	
80% paid by Medicare	- 60	
Patient copayment	<u>\$ 15</u>	(due from patient)
Due from patient	\$ 40	
Sliding fee scale write-off	- 30	
Net due from patient	<u>\$ 10</u>	

Recap

Write-off as a reduction	\$ 25
Paid by Medicare	60
Write-off on sliding fee scale	30
Due from patient	10
TOTAL	<u>\$125</u>

6. Example D

Same as C, except the patient also had \$20 of noncovered services, resulting in a total bill of \$145.00 of which \$125 is billable to Medicare.

Billed to Medicare	\$125	
Allowed by Medicare	-100	
Written-off as reduction	<u>\$ 25</u>	
Allowed by Medicare	\$100	
Patient deductible	- 25	(due from patient)
	<u>\$ 75</u>	
80% paid by Medicare	- 60	
Patient copayment	<u>\$ 15</u>	(due from patient)
Deductible and copayment due from patient	\$ 40	
Noncovered service charges due from patient	+ 20	
Total due from patient	<u>\$ 60</u>	
Sliding fee scale write-off	- 45	
Net due from patient	<u>\$ 15</u>	

Recap

Write-off as a reduction	\$ 25
Paid by Medicare	60
Write-off on sliding fee scale	45
Due from patient	<u>15</u>
TOTAL	\$145

NOTICE

THIS PRACTICE HAS ADOPTED THE FOLLOWING POLICIES
FOR CHARGES FOR HEALTH CARE SERVICES

We will charge persons receiving health services at the usual and customary rate prevailing in this area. Health services will be provided at no charge, or at a reduced charge, to persons unable to pay for the services. In addition, persons will be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of their inability to pay for the services, or because payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignments under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency which administers the State plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to person entitled to person entitled to medical assistance under the plan.

We will discuss the policies with you if you ask.

If you have discussed the policies with us and remain of the opinion that we are not fulfilling the policies set forth above, you are free to write to the following address to explain why you believe the policies are not being fulfilled:

National Health Service Corps Unit
PHS, Region _____
Street Address _____
City, State, Zip _____